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THE SOUTH AFRICAN ELDERLY:
NEGLECT, SOCIAL CONTRIBUTION AND THE HIV/AIDS EPIDEMIC

by

ALESSIA FRISOLI

A master’s thesis submitted to the Graduate Faculty in Liberal Studies in partial fulfillment of the requirements for the degree of Master of Arts, The City University of New York
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This manuscript has been read and accepted for the Graduate Faculty in Liberal Studies satisfying the thesis requirement for the degree of Master of Arts.

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Abstract

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ALESSIA FRISOLI

Advisor: Professor George Andreopoulos

With a slowing fertility rate and an increasing longevity, the world population is aging. Both developed and developing countries have seen their elderly become more numerous with an increasing burden on their financial, medical and social system. Many scholars have suggested immediate change of policies to contain the predicted crisis that will affect the health care and the pension schemes in the next decades. However, few have investigated the positive role that the seniors play contributing to society, beyond the complications caused to the economy and welfare system. This thesis will support the argument that the elderly, if appropriately cared for, can provide an important contribution to society. In this paradigm, the state has the responsibility of protecting the elderly’s human rights, according to its international commitments, as these enable seniors to reach their full potential and to keep playing a crucial role of social support. As supporting evidence, the case of South Africa will be explored. There, for decades, older persons’ rights have been neglected. Most importantly, notwithstanding their poverty, racial inequality and health issues, South African seniors have been of crucial importance in filling a gap in services left by the state helping the HIV-positive, raising orphans, providing support thanks to their pensions and spreading awareness on medical issues. This paper will first survey the human rights and the common issues of the elderly, to then focus on South Africa’s violations and
condemnations received by monitoring bodies. The discussion will then specifically investigate the role of a few structural factors (poverty, inadequate health services, education and pensions) in creating the dire situation that the elderly are forced to face, to then explore how HIV/AIDS exacerbates the seniors’ struggles. In conclusion, the argument will be made that this case study shows how, when the elderly are empowered, educated and cared for, they can be an important social resource for the care of younger generations. Their issues should therefore be more researched and their role in society and policy-making valued.
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Is the World Population Aging?

The world population considered as senior (over 60) is increasing in number at an unprecedented pace as a result of low fertility, low immigration and long lives. Before considered an issue only by developed countries, now the phenomenon is becoming evident in developing countries too (Thailand, Vietnam, India and so on). Globally, the number of older persons is expected to more than double, from 841 million people in 2013 to more than 2 billion in 2050 (United Nations DESA, 2013). According to the 2010 Report of UN Secretary-General to the General Assembly, two-thirds of the world’s older people live in low-and middle-income countries and this proportion will rise to 80 percent by 2050 (United Nations, 2010). This is because the older population in less developed regions is growing at a faster pace than in the more developed areas (United Nations DESA, 2013).

The year 2050 is expected to be the first in human history where there will be more persons over 60 than children in the world. More than one in five of the world’s population will be aged 60 or older. Among those in this age group, women already outnumber men and are twice as numerous among those aged 80 or over. The oldest-old group (aged over 85 years) have over past decades been the most rapidly expanding segment of the population in developed countries. This group is also the most susceptible to disease and disability.

Development of mortality, disease, and disability rates in elderly people will therefore have a fundamental effect on the sustainability of modern society. If the pace of increase in life expectancy in developed countries over the past two centuries stays constant through the 21st century, most babies born since 2000 in France, Germany, Italy, the UK, the USA, Canada and
Japan will likely celebrate their 100th birthdays (Christensen, Doblhammer, Rau & Vaupel, 2009). Seen these expectations, the topic of elderly protection and the issue of elderly abuse could not be more pressing.

**Conceptual Framework**

Contrarily to the common narrative seeing the elderly as a burden to the pension, medical and socio-economic system, this paper will explore the positive contribution of the seniors vis-à-vis the social neglect towards them. How we can positively include them in the society? How can we support the elderly in their role of care givers? To tackle these questions, this paper will survey the current human rights framework on the protection of the elderly to clarify state responsibilities, commitments and human rights violations.

Although it is agreed that “the dignity of all persons merits such support irrespective of their ‘use value’ to others” (Quinn & Degener, 2002) and therefore seniors are entitled to the respect of human rights and social support regardless of their utility and their potential contribution to society, it will be argued that obviating to the neglect and providing better support for the elderly would increase their social contribution and allow them to reach their social potential. This argument will be proved through the case of South Africa, where the elderly provide an example of strength and social support, notwithstanding serious hardships. The structural issues of culture, poverty, lack of education, inadequacy of pensions and health issues (specific to the country of South Africa) will be explored. Adding to this, HIV/AIDS has been chosen as one of the most relevant variables that affected this society in particular, seen its extremely high incidence. It will therefore be explored extensively as it is a decisive factor which makes it even harder for the elderly to cope with the neglect.
It is important to note that this analysis does not claim to have a unique and comprehensive explanatory power on South African elderly’s issues, nor on the reasons why they find themselves to have to step up and provide support. This study does not mean to provide a monocausal explanation to the existence of the generational gap that forces elderly to become caregivers, but it intentionally focuses on HIV/AIDS as a variable of choice because of its unprecedented impact on the country. The goal is to offer an analysis focused on the intersection between multiple compounding causes: structural issues and HIV/AIDS. It is in the interaction between these elements that the complex causation of elderly’s issues in South Africa lies. The epidemic is only one of the factors exacerbating elderly’s situation and will be analyzed in the context of an already critical structural setting.

Other variables could be identified and explored but were not for a matter of time and space constraint. Furthermore, the contribution of civil society is only briefly mentioned and not explored in detail, although it is agreed that NGOs can play a decisive role with support programs to the elderly and HIV/AIDS affected population. Instead, the South African state’s responsibility will be examined from the grounds of human rights law and international law’s commitments.

**What Are Older Persons’ Most Common Issues?**

The human rights of the elderly have been traditionally somehow overlooked. But seen their growing presence in the world population in the near future, increasing attention has been given to their issues in the last few years. For example, the UN Special Rapporteur on the right to health has highlighted that the rights of older persons are often considered to be a marginal area in human rights, and has advocated that States must adopt policies to reverse this (devoting more
resources to geriatric health care and focusing on treatment for long-term and chronic pain) (UN News Center, 2001). Furthermore, for the first time in 2010, the Report of the Secretary-General to the General Assembly focused on the human rights of older persons and identified four main challenges, which older persons are facing in terms of human rights, as discrimination, poverty, violence and abuse as well as the lack of specific services. (United Nations, 2010)

Ageism has been found to be prominent in developed countries (Abrams, Russel, Vauclair & Swift, 2011) and is often combined with other forms of discrimination, on the grounds of gender, race and ethnicity, religion, disability, health or socio-economic conditions. Poverty among the elderly causes homelessness, malnutrition, unattended chronic diseases, lack of access to safe drinking water and sanitation, unaffordable medicines and treatments and income insecurity. Violence and abuse (physical, emotional and/or sexual by someone in a position of trust and financial exploitation) are far too common globally and frequently go unreported. Finally, the growing demand for specialized services such as residential centers, long term home-care programs or geriatric services, paired with the lack of resources, creates a shortage of specific care services necessary to guarantee the human rights of older persons.

**Challenges and Possible Solutions**

The lack of funding to support the growing elderly population is just one of the issues burdening the welfare system of states. While the number of people in retirement age (typically considered 65 and over) is already beginning to strain retirement financing, a growing number of people ages 75+ will also challenge the health care systems. The proportion of those requiring more frequent medical attention is expected to increase along with a need for more nursing home facilities and increased burden of non-communicable diseases such as strokes and diabetes. An
often-used indicator to measure the severe challenges for the traditional social welfare state is the old-age dependency ratio, which divides the number of people at retirement ages by the number of people at working ages (15–64 years). Large increases in both number and proportion of elderly individuals are forthcoming in European countries, Japan, the USA, and many other countries (Christensen et al., 2009).

One way governments have tried to cope with this issue is by raising the typical age of retirement. Improvements in health and the increase of job positions using knowledge and not physical strength have allowed a rising proportion of people in their 60s and 70s to contribute to the economy (Haub, 2011). This is the strategy adopted by European countries (Italy, Spain, Greece and Ireland are looking to increase their retirement ages to between 67 and 69 by 2050), which are currently trying to raise retirement ages to both reduce the outflow of pension funds and increase the amount of social taxes received (Cha, 2012). Even China has been forced to confront the aging of its population and has famously announced plans to reform the mandatory retirement age by 2017 (Wong, 2015).

Another solution to the pension issues may be the redistribution of work. By working part-time, individuals could combine work, education, leisure, and child-rearing in varying amounts at different ages. Preliminary evidence suggests that shortened working weeks over extended working lives might further contribute to increases in life expectancy and health (Christensen et al., 2009).

People are not only living longer than they did previously, but they are also living with less disabilities and fewer functional limitations. The experience of Japan shows indeed that age is not the dominant driver of rising health costs as countries can manage expenses by emphasizing preventive primary care and reforming pharmaceutical purchasing policies. Wise
investments can increase people health and productivity for years. Japan’s introduction of universal health coverage led to more treatment for high blood pressure, and therefore fewer strokes (Ryan, 2014).

**The Evolution of the Elderly’s Human Rights’ Protection**

Human rights law provides protection for essential human rights, including the right to the enjoyment of the highest attainable standard of physical and mental health, freedom from torture, inhuman or degrading treatment and equality before the law as well as for an adequate standard of living without discrimination on any grounds. These norms apply to all social and age groups. Therefore, they also protect seniors. But contrarily to many other vulnerable groups (children and persons with disabilities), very few tools contain specific mention to the elderly. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families includes ‘age’ in the list of grounds for discrimination (Article 7): “States Parties undertake, in accordance with the international instruments concerning human rights, to respect and to ensure to all migrant workers and members of their families […] without distinction of any kind such as to sex, race, […] age, economic position, property, marital status, birth or other status” (UN General Assembly, 1990).

The Convention on the Rights of Persons with Disabilities also includes references to older persons in Article 25 (b) on health: “States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health […]. In particular, States Parties shall […] provide those health services needed by persons with disabilities […] including among children and older persons.” Another mention is made in Article 28 (2)(b) on adequate standard of living and social protection: “States Parties […] shall take appropriate steps
to […] ensure access by persons with disabilities, in particular […] older persons with disabilities.” There are additional references to age-appropriate access to justice in Article 13 (“States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations”) and to age-sensitive measures of protection in Article 16 (“States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance”) (UN General Assembly, 2007).

Finally, the Convention on the Elimination of All Forms of Discrimination against Women includes a reference to old age in relation to the elimination of discrimination against women in the enjoyment of the right to social security in Article 11.1 (e): “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular: the right to social security, particularly in cases of retirement, unemployment, sickness, invalidity and old age and other incapacity to work, as well as the right to paid leave.” (UN General Assembly, 1979).

Age was formally recognized as a form of discrimination by the International Labour Organization (ILO) through Recommendation No. 162 in 1980, which called for measures to prevent discrimination in employment and occupation within the framework of a national policy to promote equality of opportunity and treatment of workers, whatever their age.

Some treaty body monitoring mechanisms have applied existing provisions to protect the rights of older persons, notably the Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women, by providing interpretative
guidance on existing norms. For example, in the General Comment No. 6, the Committee on Economic, Social and Cultural Rights explained that it is “of the view that States parties to the Covenant are obligated to pay particular attention to promoting and protecting the economic, social and cultural rights of older persons,” and offered the first detailed interpretation of the specific obligations of States parties to the International Covenant on Economic, Social and Cultural Rights regarding older persons and their rights (UN Committee on Economic, Social and Cultural Rights, 1995). More recently, in 2010, the Committee on the Elimination of Discrimination against Women adopted General Recommendation No. 27 on discrimination against older women, the protection of their human rights under the Convention and state obligations: “States Parties must recognize that older women are an important resource to society, and have the obligation to take all appropriate measures, including legislation, to eliminate discrimination against older women” (UN Committee on the Elimination of Discrimination Against Women, 2010).

Even though no document protecting specifically the elderly exists in international law, the development of few international guidelines showed the international community’s rising interest in the rights of seniors: the Vienna International Plan of Action on Ageing, adopted at the World Assembly on Ageing in 1982; the 1991 United Nations Principles for Older Persons; the 1992 Global Targets on Aging; and the 1992 Proclamation on Ageing (Help Age International, 2000).

The Madrid Plan of Action on Aging in 2002 was endorsed by the General Assembly in its resolution 57/167 and emphasized the need for international cooperation and dialogue to create better assistance delivered to seniors through national programs. Although it is not legally binding, it was agreed upon by 159 governments. Some of the goals that the international agenda
established for the protection of older persons were the elimination of age discrimination, neglect, abuse, violence, the right to work, the right to health, participation and equality of opportunity throughout life and inclusion in decision-making processes at all levels. The priorities set by the declaration also included pensions, disability insurance and health benefits; and sufficient minimum income for all older persons, with particular attention to socially and economically disadvantaged groups, the importance of continuous education, prevention, equal access to health care, the impact of HIV/AIDS in respect to older persons and the full functionality of supportive and care-giving environments. It also called for governments to include older people in policies and programmes to reach the Millennium Development Goal of halving the proportion of people living in extreme poverty by 2015 (Union, 2003).

South Africa’s Commitments Under International Law

The responsibilities of the South African government towards the elderly are clearly stated in its commitments under international law. The government is a signatory of the declaration approved at the United Nations General Assembly Special Session (UNGASS) in 2001, with which member states committed to enact “national policies and strategies... [that] provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS” by 2005 and to “review the social and economic impact of HIV/AIDS at all levels of society, especially on women and the elderly, particularly in their role as caregivers” (UN, 2001).

South Africa has also committed as a UN member state to the Millennium Development Goals (including the objectives of reversing the spread of HIV/AIDS, poverty reduction, hunger reduction, implementing universal primary education, gender equality, and improved child health). Membership to the UN also assumes commitment to the Madrid International Plan of
Action on Ageing (2002), which commits member states to “introduce policies to provide […] support, health care and loans to older caregivers to assist them in meeting the needs of children and grandchildren in accordance with the Millennium Declaration” (University of the Western Cape, 2011).

African regional agreements are also in place. The African Union Policy Framework and Plan of Action on Ageing (2002) commits member states to regionalized policy action to benefit older persons, and the African Charter on Human and Peoples' Rights (“African Charter”) considers the protection of the elderly in Article 18, alongside the protection of the family and of women. Article 18 states: “The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs” (African Charter on Human and Peoples' Rights, 1981).

The scope of the rights protected by this provision is not immediately clear because there are very few instances in which the African Commission on Human and People’s Rights, the supervisory body empowered to monitor compliance with the African Charter, has made references to the rights of the elderly. For example, on the rights of persons with disabilities, the Commission stated that “States Parties shall recognize that older persons with disabilities have full enjoyment of human rights and fundamental freedoms on an equal basis with others” (African Commission on Human and Peoples’ Rights, 2015). Nevertheless, it is important to note that Article 18(4) also recognizes the elderly as a vulnerable group that deserves special protection (Pinzón & Martin, 2003).

South African Policies on the Elderly

Notwithstanding the aforementioned human rights law framework applicable in the protection of
the elderly, the South African government has given very little consideration to supporting older persons – either to support them in their roles as caregivers or in their loss of support structures as their adult children succumb to the HIV/AIDS (Ferreira, 2004). In the past, the institution of apartheid shaped the regulations on the elderly and its the effects can be seen until today.

With the introduction of the National Welfare Act of 1965, all social services to older persons became part of institutionalized apartheid. Then, in 1968, the Aged Persons Act provided for the establishment and maintenance of residential homes for the aged, but only White (Ministerial Committee on Abuse, 2001). The evolution of these policies echoes the racial inequality that affects South Africa: 600 homes and 400 housing complexes were built for 58,000 older White persons from 1968 to 1993; in contrast, only 11 homes were created for older Black persons, accommodating approximately 1,200 older people. This situation carries out in the present as housing schemes are still exclusively available to White elderly, while Black elderly are forced to seek residence in private homes or are left without accommodation. The lack of funding causes management and staffing problems in private homes, compromising the quality of the service (Department of Social Development, 2001b).

The Domestic Violence Act of 1998 is applicable in cases of abuse of older persons. Protection orders can be issued for victims of abuse with or without their consent. The Act also provides protection from family members besides spouses, such as children, grandchildren or other family members. The definition of abuse in the Act is wide, taking into account physical, emotional, psychological, financial and other types of abuse that are encountered by older persons. Once again, although this Act is a comprehensive one, it does not reach the elderly population that needs it the most as few older persons are aware of the protection it affords them.

The Aged Persons Amendment Act of 1998 (whose regulations were published in 2000)
stipulated conditions regarding the use of subsidies, monitoring compliance regarding conditions for registration of homes, requiring reporting of cases of abuse and the setting up of a national register on abuse of the elderly. The regulations facilitated investigation by designated bodies and established the use of warrants for the removal of older persons to places of safety in cases of abuse. The elderly gained protection from physical abuse, sexual abuse, psychological, emotional and verbal abuse, financial/economic abuse or exploitation, active/passive neglect or intentional neglect, violation of human rights, as well as witchcraft. Unfortunately, because of the lack of implementation of this Act, little change has taken place at grassroots level to improve the situation for older people. Even though this law aimed to improve upon the Act of 1968, it has limitations as it is directed towards residential care, where 83 percent of residents are still White older persons, and not community care (Perold & Muller, 2000).

Some other failing attempts have been made by the government through policies that did provide assistance but did not address structural problems affecting the South African society. For example, in his budget speech for the financial year 2001/2002, the First Minister paid particular attention to the plight of older persons vowing to improve the alarming state of elderly abuse reported by the Ministerial Commission on Elder Abuse (Skweyiya, 2001). The policies promoted as a follow-up to this vow however revealed to be more harmful than positive. In order to eliminate fraud and corruption, the Ministry of Social Development undertook the massive task of re-registering all pension beneficiaries in 2001. Instead of expanding benefit coverage, the structural issues affecting South African society nullified the effect of the plan. As a result of the lack of education, many pensionaries fell destitute without a source of income during the transitional period (Reddy, 2002). The Minister himself recognized that the system of social grants was not working correctly because of the poor attitude of the officials, the delay in
processing applications and because of lack of refunds to those affected.

In March 2006, the South African Parliament passed the Older Persons Act 13 (OPA), which provided a comprehensive framework to advance the rights of older persons, created mechanisms of protection and put in place structures of support within the community. In this case, budgetary constraints have limited the full implementation of the Act in its developmental approach. Moreover, incidents of abuse and neglect often originate with caregivers who may be family members with whom the older person resides. The fact that the OPA fails to accord any rights to older persons on matters potentially concerning their family, housing and health, not to mention their privacy and finances, is a grave oversight (University of the Western Cape, 2011).

Reports of Elderly Abuse in South Africa by Monitoring Bodies

Although from its public speeches and policies the South African government seemed to cooperate with the international guidelines towards the improvement of older persons’ rights, reports from human rights monitoring bodies reveal the ineffectiveness of these measures.

One of the main reported issues of the elderly in South Africa is the lack of proper health care and specific geriatric services. Access to health services for the poor, especially in rural areas, is severely constrained by expensive, inadequate or nonexistent means of transportation, by serious shortages of emergency transport, and by long waiting times at clinics and other health care facilities. Older persons often complain about a whole range of health issues, from lack of respect to shortages of medication and long waiting times. Confirming these grievances, the findings in the SAHRC’s 7th Economic and Social Rights Report 2006–2009 highlighted the insufficient access to health care for vulnerable groups such as women, sex workers, prisoners and older persons (University of the Western Cape, 2011).
Similarly, the Human Science Research Council conducted a survey on the health status of older persons in all communities in South Africa. The findings gave a vivid picture of the realities facing older persons: less than 50 percent of Black elderly receives medical care versus 99 percent of Whites; in rural communities less than 30 percent of Black elderly receive care; and a higher percentage of Black elderly are dependent on others for daily care, confirming that a substantial number of frail Black persons are living at home which contributes to abuse. Furthermore, virtually no elder Blacks, coloureds or Asians have medical insurance (Ministerial Committee on Abuse, 2001).

Another esteemed monitoring body which has highlighted the problematic aspects of the South African government’s treatment of HIV/AIDS ill is the Universal Periodic Review, a mechanism of the Human Rights Council (HRC) aimed at improving the human rights situation on the ground of each of the 193 United Nations (UN) Member States. South Africa has submitted reports and was reviewed in 2 cycles (2008 and 2012). During the first cycle (2008), the issue of HIV/AIDS was raised by Germany, which asked what measures were in place to grant access to care for women suffering from HIV, and Canada, which focused on the access of rural population to medicines. In the session outcomes, Canada highlighted that “there is still inequitable access to antiretroviral treatment and a lack of support services, particularly for rural women” and recommended “that measures be taken to address inequities in access to HIV/AIDS treatment and support, particularly in rural areas” (UN Human Rights Council, 2008).

Similarly, Mexico requested more information on ethnic minorities’ access to health care; Algeria suggested to intensify efforts on the National Health Charter with a special focus on teenagers; Germany highlighted the importance of prevention and Romania recommended an increase in measures to eliminate the discriminatory barriers to access health services. The South
African delegation responded to these criticisms by saying that “a significant amount of resources had been put aside to ensure there is equal access to health-care facilities and services so as to ensure appropriate access to treatment for health-related conditions.” The delegation also remarked that thanks to the Medicine Pricing Regulations of 2004 there had been a decrease in HIV rates among the younger population, showing ongoing progress (UN Human Rights Council, 2008).

The second cycle of the Review, in 2012, was less focused on HIV/AIDS. South Africa reported improvements in its counseling, testing and treatment capacity of the disease, as well as an increase in the number of patients accessing antiretroviral therapy, from 500,000 in 2008 to 1.9 million in 2012. China, Morocco, Australia, Romania, Singapore, Iran, Ireland, Japan, Spain, Portugal, Sri Lanka and Mexico recommended intensifying efforts in favor of prevention, equal access to care and against mother to child transmission of HIV/AIDS (UN Human Rights Council, 2012).

Residential care facilities for older persons have also been condemned for clearly not upholding elderly’s right to adequate housing. The Department of Social Development recently conducted an audit of residential facilities subsidized by the state in order to identify the services provided and assess their quality, while also identifying the management systems used to run these facilities (Department of Social Development, 2010). The findings of the study demonstrate that the majority of residential facilities are in no state to comply with the norms and standards in the Older Persons Act of 2006 and would require a huge financial investment to do so. This is yet another indication of the gaps that remain in the implementation of the constitutional and legislative obligations regarding older persons (Statistics South Africa, 2010).

Abuses of elderly in nursing homes are also far from uncommon. Over the years, the
South African Human Rights Commission (SAHRC) has investigated quite a few facilities in which abuse has occurred, and found that unless proper monitoring mechanisms are in place, the ineffective and inefficient running of facilities goes unnoticed. It was also apparent during site inspections by the SAHRC that the duty of care by personnel occurred outside a human rights framework and that older persons were unaware of their rights. Therefore much needs to be done to inculcate a human rights culture in many of these facilities.

Elderly abuse in South Africa has been extensively documented. In a survey for the National Department of Health, the Africa Strategic Research Corporation (1999) found that 69 percent of South African respondents were aware of abuse of older people, and over half (53 percent) had personal experience of abuse. The three main types of abuse identified by the respondents were psychological or emotional; financial; and general maltreatment. Theft of pensions by grandchildren, and working without payment were the most common forms of financial abuse. Grandchildren were reported to be responsible for more than one-half of the abuse of older persons, followed by spouses and children. Victims of abuse are usually 70-80 years of age, overwhelmingly female, and suffering from illness or disability. The abusers are usually in the ‘near old’ category or in very young age groups, distributed proportionally between men and women, and are most often a family member (May, 2003).

The survey by the Department of Health confirmed that financial abuse is the most prevalent type of elderly abuse with over 90 percent of the cases of abuse perpetrated by family members (Africa Strategic Research Corporation, 1999). In some cases older persons had to hide their precarious situation from outsiders because of the fear of beatings from their children, living in private homes in very poor conditions. Besides entire households being dependent on the pensions of these older people, which constitutes financial abuse on its own, these older
people were sometimes abused by their families because of their pension. Older persons reported losing control of their money when family members demanded that they hand it over. This was a source of great emotional stress for them. Financial abuse also takes the form of children expecting older persons to care for grandchildren and perform housework without being paid. Sometimes older persons were expected to pay for grandchildren’s’ food, shelter, clothing and school fees. Older people, because of their physical limitations, are also easy targets for assault and robbery, especially after receiving their pension money. These are often combined with rape of older women.

The Minister of Social Development established the Ministerial Committee to principally determine direct and indirect causes of abuse, collected and reviewed research and other relevant data. The Committee found that at every Public Hearing older people gave accounts of the distress caused by abuse from their children and grandchildren. In addition, the report reflects that the rape of older persons is on the increase, both within the family and by outsiders who believe that sexual intercourse with a sexually inactive person can cure HIV/AIDS. Further, older people living alone are dying from malnutrition and neglect (May, 2003). Finally, since the 1990s, several studies have documented and corroborated the overload and the understaffing of the health care services and the widespread degree of elderly abuse. (e.g. Eckley & Vilakazi, 1995; Joubert, Swart & Reddy, 1998; Conradie, 1999; Keikelame & Ferreira, 2000; Mosaval & Ferreira, 2000).

The Value of the South African Case

Attempting to trace the history of elderly abuse in South Africa is not an easy task because of its hidden nature. The older people view poverty, unemployment and the subsequent use of alcohol
and drugs as root causes of abuse. The increasing westernization of society, the loss of traditional values, and the breakdown of family structures that brings with it disrespect and disregard for older persons are also blamed for the increasing levels of abuse. In addition, both the lack of education and too much education are held responsible for the poor treatment of older persons. The government is also held accountable for being too liberal with young people, as in banning corporal punishment and failing to provide adequately for older persons (Keikelame & Ferreira, 2000). Older women in particular felt that the burden for the care by them of large numbers of dependents could be alleviated if government increased job opportunities for the younger generations. Although the unsettling perception that the elderly feel may have its validity as their society has changed from what used to be considered the “traditional” structure, the complex causation at the foundation of their situation may lie in a combination of factors and not in just one leading cause.

All Sub-Saharan Africa is affected by a wide range of economic, social and political problems besides the HIV/AIDS epidemics: extreme disempowering and debilitating chronic poverty; economic recessions, foreign debt, the effects of economic structural adjustment programmes and massive unemployment; underdevelopment and poor infrastructure; weak leadership, poor governance and corruption; political instability, conflict and violence; pervasive patriarchy with women discriminated against and disadvantaged; the effects of droughts, floods and pestilence on agriculture, livelihoods and food security; and rampant disease, including malaria, tuberculosis, waterborne disease and malnutrition. However, here the combination of extreme poverty, legacy of apartheid and of traditional social/family structure makes it uniquely hard on the especially vulnerable group of elderly (less educated, poor, Black South African elderly living in countryside) to face on of the highest incidence of HIV/AIDS in the region. The
several intersecting factors at play in the case of South Africa create a multiplier effect that compounds the structural problems and results in the extremely complicated realities that the elderly are forced to face in South Africa.

Southern Africa is the subregion worst affected by the pandemic globally, and within it, the incidence of HIV/AIDS has been especially high in Botswana, Zimbabwe and South Africa, among all African countries (Ferreira, 2004). Many older people become involved in stressful and exhausting situations while HIV/AIDS campaigns tend to target mostly younger people. For this reason, older people’s knowledge and awareness of the illness is low. The lengthy periods of illness and disability caused by HIV/AIDS, the untimely nature of the death, and stigma of community further burden the elderly (Leete & Jacobs, 2002). Notwithstanding these harsh conditions, seniors have been coping with these situations providing an invaluable and much needed service to society. This makes the need for seniors’ support in the form of income, education campaigns, health-care, physical help and counseling services all the more acute.

So, if on one hand South Africa has suffered as few others from the epidemic of HIV/AIDS, what makes this case study uniquely interesting is that the elderly in this country have provided an example that stands strong against the myths describing older people as a burden to society. While poverty and HIV, combined with the specific social and economic issues of this society, did worsen the already heavy burden on the neglected elderly, the struggle also offered them the opportunity to demonstrate their strength and the vital social role that they can play in the future if nurtured. Secondly, the important lesson taught by this case study should remind us of the overlooked value of the neglected who should be assisted and cared for as an end in itself and not just as a tool to provide for other age and social groups.

While the discussion has until this point treated the issue of elderly abuse in general
(highlighting the importance of prioritizing elderly’s rights seen global aging and the unsuccessful character of the measures taken by the South African government), the analysis will now center on the life of the elderly in South Africa.

THE CASE OF SOUTH AFRICA

How is the population in South Africa Aging?

While being unique in their set of issues comparing to the rest of the world, Sub-Saharan African countries present some common traits. The population aging rates are slower than in the rest of the world and birth rates are still quite high. Because of the considerable time required following fertility decline for the shift in age distribution to become apparent at older adult ages, the greater part of the aging process in least developed countries is still to come. A generally faster rate of fertility decline will lead to a more rapid pace of aging, the effects of which will rapidly affect these countries and will lead to similar issues to the ones developed countries are facing now. (Leete et al., 2002).

South Africa is home to over 54 million people with a quite high total fertility rate of 2.41, somewhat offset by a life expectancy of 56 years for the population overall (The World Bank, 2011). The number and proportion of elderly persons aged 60 years and older relative to those aged 59 and younger has increased from 2.8 million in 1996 to 4.1 million in 2011. The proportions of older people in the population is still just 8.0 percent, but this share is expected to more than double by 2050 making the issue of elderly’s rights and care more pressing. The sex ratio among elderly increased from 64 to 66 elderly men per 100 elderly women over the period
1996–2011, confirming women’s predominance but also suggesting an improvement in health among men. South Africa confirms the widely recurrent pattern that the issues of older people are principally those of women (Statistics of South Africa, 2014).

Discussing all the issues affecting South African society is not feasible for space constraints of this paper. Instead, this discussion will focus on a few issues that are key in determining the mechanism through which the human rights framework and policies in place in South Africa, if any, are subverted. The main direct causes are the lack of awareness on rights, entitlements (if there are any) among the elderly, while the root causes are much deeper. The attempted policies to protect older persons, some of which have been described above, have been either fatally flawed (not reaching the part of population who needs them most) or simply ineffective. For example, South Africa is one of the few countries in Sub-Saharan Africa to have a pension system or social welfare in place, which is a very important source of sustainment for the elderly. However, many do not benefit from it as they rightfully could (Leete et al., 2002). This is just one of the examples embodying the structural issues that we will explore in order to shed light into the complex social dynamics of South Africa: culture, poverty, pensions, lack of education and health. While this analysis will not cover all possible aspects contributing to the hardships endured by the elderly, it is important to deal with these themes in order to explain the complexity of the issues faced and the ineffectiveness of the solutions attempted.

**STRUCTURAL FACTORS**

**Culture (Apartheid and Family Structure)**

In traditional African patriarchal societies, older men were the principal authority figures both in
their households and in the wider community. In South Africa, rapid social change and the transition to a democratic government are transforming the traditional family relations to some degree. In 1996, only 6 percent of Africans were living alone (Hosegood & Timaeus, 2006) due to very low marriage rates, low rates of cohabitation in non-marital relationships, the dependence of children and younger adults on the economic and material support of older people, the limited availability of land and the high cost of housing. In contrast, other phenomena, such as matrifocal and other women-headed households, have emerged and become a common household arrangement in both rural and urban areas (Preston-Whyte, 1988).

The failure of the law grounded in patriarchal understanding of society to recognize customary marriages meant that husbands could subject older women to economic abuse by denying them access to matters concerning the estate. With the recognition of the Customary Marriages Act, 1998, equal power was given to women to manage their joint estate.

Women who lived longer than men in South Africa were particularly hard hit in old age upon the loss of their husbands. Due to the failure of the South African succession law on estates to include Black South Africans, Black women were often left destitute when their husbands died because the estate was handed over to the first-born male, leaving the mother at the mercy of her son. The amendment has now brought the law into line with the principle of gender equality as stated in the constitution, and now provides protection to elderly Black women. However, older women in South Africa, a large percentage of whom are illiterate and have lived a subservient life, still struggle to have their rights enforced. These are all examples of how the patriarchal system, even after the proclamation of gender-equality based laws, still plays an important role in social dynamics in South Africa. Similarly, the apartheid has been gradually de-institutionalized, but created socio-economic conditions of inequality that still have implications today.
South Africa’s history of apartheid and labor migration profoundly influences the contemporary life of South African Black elderly. In particular, besides the obvious racist character of the apartheid policies, the consequent labor migration patterns modified the ‘traditional’ African family structure. The Apartheid Group Areas Act and the labor migration system systematically divided African families by recruiting younger men and women to the centers of employment, while restricting the movement of the dependent children. In this context, older people facilitated the economic migration of younger adults by caring for their grandchildren and safeguarding the family land and assets. This became essential to both maintaining the labor migration system and ensuring the long-term survival of households. Consequently, in South Africa the role of older people, particularly grandmothers, in caring for children affected by HIV builds on a long-established set of social structures related to child care (Schatz, 2007). Skip generation households in which middle generation family members are absent are increasingly common not just because of migration but because young adults are now increasingly infected with HIV and later succumb to AIDS related deaths, whereafter grandparents, typically a grandmother, become caregivers to orphaned grandchildren, so forming a skip generation family unit (Ferreira, 2004). Other reasons may be pointed out, but will not be considered for the scope of this paper.

Most older persons in South Africa live in extended households which reflects what is supposed to be the traditional role of family in supporting health of the elderly. In this paradigm, the younger generations, who are now healthy and fit to work, ‘give back’ to the elderly who raised them by caring for their health and maintenance. Older people care through the family is located within the spirit of Ubuntu, which is an African philosophy meaning that ‘people are people through people.’ It acknowledges the rights and responsibilities of every citizen in
promoting individual and social well being (Oakley, 1998). It calls for a reversion from a racially divided system of institutional care to family and community care. Ubuntu is in line with the United Nations’ and WHO recommendation for the move away from state dependency to individual and family care. However, the belief that the traditional value of care for the ill, elderly and disabled is a shared responsibility of the family, has possibly changed. The expectation that elderly should be cared for by the younger generations has in some cases turned upside down because of rapid social change and because of the high incidence of HIV/AIDS.

**Poverty**

The majority of South African older persons, because of the indignity of apartheid, in addition to the emotional trauma, are still caught in the grip of poverty that is unlikely to end in their lifetime. In fact, a study initiated by HelpAge International in South Africa recorded the impact that historical policies have on the lives of older persons, creating emotional and material poverty, the effects of which they battle with on a day-to-day basis (Heslop, Agyarko, Adjetey-Sorsey & Mapetla, 2000). Living conditions of the elderly living in private homes (the majority) with their extended families caught in the grip of poverty are dreadful. They endure the hardships of lack of basic services like water and sanitation. It is estimated that 13 percent of older persons live in homes with no toilet, and 25 percent lack access to any water (Department of Health, 1998). A study carried out as part of the International Year of the Older Person (IYOP) to determine the knowledge, perception and needs of older persons in South Africa, highlighted older persons’ desire for adequate housing with electricity, water supply and sanitation (Jourbet et al., 1998). Moreover, in cases where the adult generation cannot provide assistance, for instance being sick with HIV or being unemployed, the structure of the family changes
completely: the elderly provide through pensions, if there is any, both for their children and
grand-children.

This issue affects mostly elderly women as their proportion living in extended households
is twice that of their male counterparts. Six in ten elderly women reside within extended
households while over a third of elderly men resides in nuclear households. Single-member and
nuclear households were found predominantly among the White population group while 40
percent of large households (five or more members) were predominantly among Black African-
headed households. This shows the extent of economic and social responsibilities that elderly
persons continue to provide to their significant others through their pension, notwithstanding
their poor socio-economic conditions.

Poverty as a result of the apartheid is visible especially through the gap in socio-
economic status between White and Black elderly persons. This indicator depicts the impact of
marginalization and lack of opportunities of Blacks in the past. The proportions of rich White
elderly persons were found to be ten times higher than that of Black African elderly persons
(80.7 percent and 8 percent respectively) (Statistics of South Africa, 2014). The levels of
education and the fact that rural provinces have higher proportions of poor elderly persons
compared to those residing in the urban provinces mirrors once again apartheid policies’
geographical distribution of wealth.

**Lack of Education**

Under the Bantu Education Policy of the apartheid government, many Black children, currently
the older persons of South Africa, lacked access to education because Black children were forced
to leave school at a young age in order to work. They had to care for younger siblings, lacked
schooling facilities or access to schools. As a result, South Africa has now 11 official languages, English being only one of them. Only nine percent of the population regards English as their home language (Central Statistics, 1997). Yet, English predominates as the official language medium, even where it is not spoken. The majority of English-speaking elderly persons (78 percent) have better socio-economic status compared to the ones speaking other languages. In contrast, more than two-thirds of elderly persons who spoke Tshivenda, Xitsonga, Sepedi and isiXhosa were poor (Burns et al., 2005). Education, location, wealth and language skills are all ways in which Black elderly are disadvantaged because of poverty in South Africa.

While most elderly persons in South Africa have no formal education, the proportion of those with no schooling improved, decreasing from 47 percent in 1996 to 28 percent in 2011. Although there have been positive developments, the degree of inability of those illiterate elderly who still did not receive education is worrisome. More than half of the elderly persons with 'no schooling' were unable to read a newspaper or fill a form and about 45 percent were unable to write their own name or calculate change after a business transaction. Illiteracy has been found most prevalent among women and among Black elderly persons, and lowest among the White population group. In 2011, almost a third (28.4 percent) of elderly Whites had attained a higher level of education, far higher than that of Black Africans (2.5 percent) (World Bank, 2015).

Taken together these statistics draw a very problematic picture of elderly South Africans, most of all Black elderly women living in rural areas. These people are expected to have the lowest education and income, and sometimes barely speak English. These characteristics (low literacy (impeding ability to count, sign and read, low English skills and low resources to seek help) make them extremely vulnerable to abuse. Being unaware of their entitlements is an active barrier to the enjoyment of their rights (pensions, entitlement and help) and lack of education and
writing/reading skills prevents them from effectively navigating the bureaucracy of entitlements. In this context, implementation of the government’s social pension schemes and other policies is problematic and usually fails. The other most common difficulties reported are access, interminable queues, cheating and lack of security.

Inadequacy of the Pension System

The implications of this data are especially relevant in the context of policy making aimed to improve the conditions of the most unfortunates through programs of social pensions and entitlements. Unfortunately, these aspects (lack of education, lack of rights awareness, gender-based social discrimination and socio-economic racist inequalities) have often been ignored.

South Africa’s policy on older persons in the form of a social pension scheme dates back to 1928 with the introduction of the Social Pension Act from which Black South Africans were excluded. Although the 1944 Pension Law Amendment Bill provided for the welfare of older Black South Africans, the value of the pension was of a mere one-tenth of that accorded White people. Finally, in 1965, under the National Welfare Act, a uniform and incremental pension scheme was made available to all Black South Africans. The Social Assistance Act of 1992 provided steps to deracialize pensions and achieve pension parity, which was finally granted only in 1993, just one year prior to the first democratic elections. By 1993, the take-up rate among eligible Black South African men and women stood at 80 percent. At this time, the maximum benefit was equal to twice the median per capita income in rural areas and three times the level of the least generous World Bank poverty line. In 2002, the pension was raised to more than twice the median monthly individual earnings of Black South Africans, becoming an important route to escape poverty for many families (Burns et al., 2005).
Nowadays, in South Africa, non-contributory pensions reach 1.9 million older persons (South African Social Security Agency, 2016). The social pension system in South Africa can be among the most far-reaching and generous in the developing world, representing the core component of the South African social safety net. The pension is a noncontributory, means-tested pension that is payable to women aged 60 and above and men aged 65 and above. Pension benefits, an amount of R700 (approximately US$100) a month, are an important source of income to poverty stricken family units. Pension sharing is common in multigenerational households, and is used to support all co-resident family members, and to pay school fees and for clothes and medicines for grandchildren.

In the context of extreme poverty when the elderly support their grand-children through school and their children through illness, the amount of pension received becomes the only income and is therefore crucial. Unfortunately, few elderly in charge of their grandchildren take advantage of Child support grants (– R180 (US$27) a month), Foster care grants (R530 (US$79) a month), Disability grants (R780 (US$115) a month) School fee exemptions (about R150 (US $22) a year for primary and R300 (US$44) for secondary) and Free antiretroviral therapy (ART) at government hospitals (Ferreira, 2015). This is because the foster care grant, much bigger than the child support grant, is only awarded when the older carer establishes legal guardianship through the children’s court, which takes at least two years, whereas the child care grant can go through within weeks. Moreover, most older Black South Africans have no birth certificate, so they have to rely on their identity papers for proof of age. But these are often inaccurate, so the person has to obtain new papers before applying for a pension. Obtaining birth certificates for grand-children and documents showing belonging to a single family is just as hard, actively complicating the granting of rightful funds for the elderly (HelpAge International Southern
The households that rely most heavily on the social pension are not only mostly Black and poorer, but are also larger in size. Multi-generational households are common amongst Black South African families, accounting for the larger household size at the bottom of the income distribution (60 percent of all Black pensioner households are three-generation households with children, compared to only 9 percent of White pensioner households). A further 14 percent of Black pensioner households are skip-generation households containing only grandparents and young children (Burns et al., 2005).

These findings resonate with other research showing that the elderly, particularly elderly Black women, are increasingly assuming the role of primary caregiver and that South Africa’s social pensions are therefore vitally important for the welfare of the unintended beneficiaries (namely, grandchildren up to the age of 18 and the unemployed or ill children). Indeed, pension receipt has been positively and significantly associated with improvements in child health status, school attendance and decreased child labor (Burns et al., 2005). In light of this evidence, providing means and pensions to the elderly would improve the devolvement of resources to all strata of society (unemployed or sick youth and dependent grandchildren). Grandparents seem fundamental for the distribution of resources and maintenance of standard of living.

**Health**

In developing countries like South Africa, lack of access to health care facilities intermingled with a life of poverty also expedites the onset of chronic diseases and ‘old age’ at a much younger age than it can be seen in developed countries. The nature of the life of women in South Africa, particularly Black-African women, is stressful, entailing multiple pregnancies, hard
physical labour (toiling on the farms, collecting water and fuel) and rearing children; and marked by inaccessibility to health facilities and therefore untreated health conditions and poor nutrition. This creates a widespread degree of hypertension, stroke, ischemic heart disease, diabetes and cancers, all chronic diseases, which are important causes of death in the 45-59 age group (South African Health Review, 2000). Almost three-quarters of the respondents in two surveys cited by May (2003) reported having at least one chronic illness or ongoing health problem, and more than half reported a disability, the most common being impaired vision. Furthermore, high rates of depressive symptomatology have been found in Black urban and rural women, when compared with the other racial groups (May, 2003).

This increased need of geriatric training and care is also coupled with a systematic lack of specialized medical care for elderly. According to a study in 1993/1994 by the Centre for Gerontology, following a request from the NGO South AfricaCA, while some training was taking place, no institution offered a comprehensive program on gerontology as a specialty (Leete et al., 2002). Gerontological and nursing courses were integrated into parts of programs particularly in medicine, psychology and sociology. Several departments engaged in postgraduate research in aging, but only to a limited extent.

In nursing training at the organizational level, the focus was chiefly on nursing care or basic care for older persons, while a holistic approach encompassing their psychosocial needs was lacking. Training was mainly in the form of in-service programs and the level of accreditation varied widely, without a set of norms and standards for accreditation across the institutions. Several organizations sent their staff for training in various aspects of geriatric care, although the number was still low. Many did not due to staff shortages or because they did not see the need for staff to undergo training.
Understaffing has made it impossible for social workers to visit old age homes, even if required by law. Social workers were assigned up to 100 homes and visits by health inspectors to homes took place once in 2-3 years. The Ministerial Report (Department of Social Development, 2001b) showed that social workers, because of their heavy caseload and the lack of statutory or legislative requirements, did not regard older persons as a priority. Social workers admitted not having the skills or expertise to manage the special needs of the elderly. Understaffing of homes and lack of qualified personnel has severely compromised the standard of care given to older persons. Finally, registered nurses comprise a very small number of nursing personnel in old age homes in South Africa, despite the fact that the majority of residents were above the age of 85 and highly dependent (Perold & Muller, 2000).

**HIV/AIDS AND RELATED ISSUES**

HIV/AIDS’s extreme diffusion in South Africa comes in the picture of an already poverty-thorn society with deep cultural and social issues, some of which were explored above. In 2013 there were 6.3 million people living with AIDS in South Africa (of which 19 percent adults) and an estimated 200,000 AIDS related deaths. The epidemic has left behind some 2.3 million children who have been orphaned by HIV (UNAIDS, 2014). HIV and AIDS have resulted in a reversal of roles, where older persons are now providing subsistence and care to younger generations. In short, “the elderly lost their caregivers, while often simultaneously becoming caregivers for their sick children and orphaned grandchildren” (Schatz, 2007).

The African extended family has traditionally nursed its sick and absorbed its orphans without legal process. Many governments and major international donors have therefore
suggested that ‘traditional’ coping mechanisms would minimize the impact, but instead the
reversal of roles in the family structure combined with the socio-economic issues that families
have to face has scattered this expectation. The elderly have experienced the impact of the
epidemic through seven pathways at the family or household level: caregiving, coresidence with
an ill adult child, loss of the child, providing financial or material support during the time the
adult child is ill, paying for the funeral of the deceased child, fostering grandchildren, and
negative community reaction (Hosegood & Timaeus, 2006).

This section will focus on a few of the most relevant implications of HIV/AIDS in the
family that affect in great measure the elderly exacerbating their hardships: the financial burden
of providing for the ill and the dependents, the physical and psychological consequences of
actively caring for them and the socio-cultural aspects of the incidence of HIV/AIDS in one’s
family. On this last aspect, two specific components were chosen to embody the implications of
the close interaction between traditional African culture and HIV/AIDS: stigma and accusations
of witchcraft. These two factors show how the structural factor of African traditional culture
exacerbates as a compounding factor the social stigma that HIV/AIDS usually causes (for
example, because of fear of contagion or discrimination from accusations of loose sexual
conduct). The degree of social ostracism that elderly are subjected to as a result of illness or
death in the family creates an unbearable burden which amplifies the suffering of the grief.

This analysis does not claim to have a unique explanatory power on the existence of
elderly’s hardships as a result of the generational gap between grandparents and grandchildren in
a family. For example, the existence and the relevance of other factors like ‘black-on-black’
violence, described as a horror which has “regular occurrence in South Africa
today” (Greenwald, 2001), are recognized but will not be dealt with in this paper. Further studies
complementing this analysis with research covering these aspects are welcome.

Another factor that must be mentioned as a compounding aspect of the HIV/AIDS epidemic is the counterproductive and deleterious position of the South African government during the presidency of Thabo Mbeki from 1999 to 2008. The denial theories (against the scientific consensus that Aids was caused by a viral infection) combined with the belief that the disease was caused by poverty, bad nourishment and general ill-health, had disastrous effects. The rejection of the offers of free drugs and grants offered by the international community and the foot-dragging on the part of the government over bringing in a treatment program precluded access to reasonably priced drugs and pushed people towards traditional healers and bogus treatments. Unlike its neighboring countries, which accepted help in providing care for the HIV/AIDS epidemic, the South African government carried out policies which instead of helping exacerbated the diffusion, becoming directly responsible for the avoidable deaths of more than a third of a million people in the country, according to research by Harvard university (Boseley, 2008). This issue will not be analyzed in depth, but, being a major failure of human rights abuse prevention on the part of the government and having caused serious deleterious implication on the health of the South African people, it needs to be acknowledged.

Another important note is that, although it will not be dealt with in detail, the macro-level economic and social impact of the HIV epidemic in Africa is an issue of great relevance in this discussion, as it affects the standard of older persons health and should therefore be considered by policy-makers. By increasing demands on or worsening the quality of health and welfare services, reducing opportunities for paid work, and adversely affecting the supply of adequate foodstuffs, HIV/AIDS affects the elderly’s health in many indirect ways. For example, water supply, sanitation, and clinic-based and hospital care are particularly important for older people
and public health expenditures in South Africa fell as a result of increased budget for HIV/AIDS care from 8.2 percent of the gross domestic product in 1994 to 4.1 percent in 2000 (Hosegood et al., 2006). Government health services, particularly in rural areas, are already inadequately equipped to provide long-term support for people with chronic diseases, and this is unlikely to improve in the context of the overwhelming pressure on them resulting from the tuberculosis and HIV/AIDS epidemic.

**The Financial Burden**

Before assuming the role of carers for AIDS orphans, older persons are burdened with financial demands relating to the health care costs and the provision of material support to both their AIDS sick adult children and the children’s dependents. In South Africa women who are 60 and over and who receive the social old age pension expend the greater part of their grant income on meeting the needs of AIDS sick adult children and affected grandchildren (Keikelame & Ferreira, 2000). Very little if any public assistance is available to persons with AIDS, but even less or nothing is available to caregivers. Persons with AIDS therefore rely on intergenerational support arrangements. If adult children live elsewhere, for migrant labour or other reasons, and if they develop AIDS, most will return to their parental home to be cared for by a parent until they die. Their living arrangements at their place of work often fail to provide them with the level of physical, emotional, and financial support that they can receive from their parents and others in their natal household. So, as many as 14 percent of the people dying in one area of rural KwaZulu-Natal in 2001-2002, for example, had arrived in the area less than 6 months before they died (Hosegood et al., 2006).

A qualitative study of grandmothers caring for a child with HIV/AIDS as well as their
grandchildren in townships in the Western Cape province of South Africa found that the cost of caring for the sick person (transport, medical bills), as well as taking on more of the costs of childrearing (school fees, food), drove the older women and their households into poverty. Still, they have commented: “any child who becomes sick in our culture, while their parents are still alive, the mother must take care of her child” (Auphrey, HIV/AIDS Household) (Schatz, 2007).

In the study, older women's caregiving responsibilities also included traveling with the sick person to the traditional healer, clinic, private doctor, or hospital to receive care and treatment. Sometimes they helped the patient walk to these places, and sometimes they paid for the transport – for an older woman the former has physical costs, whereas the latter has financial costs (Schatz, 2007).

Notwithstanding the financial burden, the elderly in South African society often express their feeling of duty towards supporting their younger generations, even though the social structure assumes they would be the ones finding support in their family once reached the old age. The seniors usually do not see their pensions as money meant specifically for their own upkeep, but rather as a subsidy for the household as a whole, or at least for themselves and their grandchildren: “I don't have any problem because I'm supporting my own blood” (Dorah, No Death Household) (Schatz, 2007).

This discussion shows how, when available, pensions make a difference and help elderly to provide for the whole family and escape total poverty. Increasing household-heading elderly’s access to grants may be one way to get more money into poor households and to help poor children, besides directly providing for the neglected older generations. Improving access and uptake of grants would essentially ‘add money’ to their pensions, thus easing some of their caregiving burden. Programs targeted at assisting elderly individuals to access multiple social grants
for their households should be implemented to improve the welfare of both pensioners and the young people in their care.

**The Physical and Psychological Implications**

In addition to the financial constraints, South African elderly reported that their health had worsened as a result of the experience of caring for HIV/AIDS ill due to the physical demands involved in caregiving and the emotional trauma that they had suffered (Ferreira et al., 2001). In one of the few longitudinal studies in Africa to investigate the impact of adult deaths on older household members, Dayton and Ainsworth (2002) found that, controlling for poverty, the body mass index of older people decreased significantly in the period immediately following the death of an adult member of their household. Physical and health effects of the strain of caregiving, additional domestic responsibilities, insufficient income and food deprivation, community stigmatization, and the emotional effects of caring for a terminally ill person and coping with the loss of a child or children to AIDS all exact an enormous toll on older persons, women in particular. The impact of AIDS on older parents can moreover be particularly harsh, given the often lengthy periods of illness and disability, and their fears for the future (Hosegood & Timaeus, 2006).

The Economic Commission for Africa (2009) reported that the health of older care-givers deteriorates as a result of the physical and emotional stress of assisting their children. The physical impact of caring for the ill, such as backache, chest and leg pains, was attributed to the frequent changing, lifting and washing of adult patients. The elderly also worry about the impending death of adult children as well as the emotional stress of nursing terminally ill relatives and being infected during the process of caring (Union, 2003). When their children
eventually die, the grandparents endure the trauma of the loss of family members and have to cope with the stigma associated with HIV and AIDS, even long after their death. Caring for grandchildren is also burdensome, since orphans often refuse to accept the authority of the older persons and the elderly experience problems in disciplining them (Union, 2003).

**Stigma**

Between elderly caregivers there is widespread ignorance of the nature and implications of the HIV/AIDS. The common understanding is that the disease does not exempt older people but commonly involves them in the role of carers. Because of the high prevalence of HIV in the younger age group, official awareness campaigns like the HIV/AIDS/STD Strategic Plan for South Africa 2000-2005 (Department of Health, 2000b) had a focus on youth. The plan was to educate the sexually active population or the potentially sexually active population. This makes sense but is also important that caregivers like grandparents, who are also sexually active, receive education on how to prevent HIV infection both for themselves and for those in their care.

HIV/AIDS affects the elderly also directly. Evidence shows that an appreciable numbers of older South Africans are HIV positive. For example, a survey conducted by the Human Sciences Research Council collected HIV data on a small number of people age 55 or more and reported that approximately 7 percent of women age 55 or more and 7 percent of men in the same age group were HIV positive (Hosegood et al., 2006). Besides caring for their own well-being, grandparents are also a potential source of counsel for the youth and for other older persons, and have an important role especially in destigmatizing HIV/AIDS in the community. The Department of Health provides training on home based care, but these programs are not
specifically for older persons as caregivers or as recipients of care. NGOs, like South AfriCA, are currently trying to fill the gap left by the government offering training to older informal unpaid caregivers in dealing with HIV/AIDS-ill children and grandchildren, as well as caring for orphaned grandchildren. In addition, South AfricaCA is launching a National Carers Association with one of its goals being to prevent and detect the abuse of older persons while in these caregiving roles (Bryan, 2001). The relevant role of civil society is therefore recognized as it provides important sources of informations for the elderly.

Stigma due to illness must also be fought through rehabilitating the image of the HIV/AIDS ill. Nowadays violent attacks to the ill are a serious danger that may kill before the virus does. This was the case on December 13, 2003, in Khayelitsha, a sprawling township outside Cape Town, where 21 year old HIV positive AIDS educator, Lorna Mlofana was beaten to death after telling a group of men in a tavern who had just raped her of her status (Cape Argus, 2003).

Besides the physical effects of the HIV/AIDS illness and the dangers to which the ill are subjected to, a death in the family also affects all relatives with secondary stigma. Ogunmefun, Gilbert and Schatz (2011) provide the case of an elderly woman who had to face not only poverty and exhaustion caused by her son and her grand-children illness but also secondary stigma after her son’s death. “Her son’s illness and death were troubling in a number of ways: she lost the income he had been remitting when he was working in Johannesburg; she had to take on the responsibility of raising his children; she had to use her pension money to pay for costs related to his illness, and later for funeral expenses. But, what worried and affected her most was how his illness and death brought shame on her and her household given its association with sexual taboos and prostitution, and she lost respect of her kin and neighbors due to stigma of the disease. Her grandchildren living elsewhere stopped visiting because there had been too much
death in the household causing her to feel isolated and alone. She worried about why her neighbors came to visit, concerned that they were simply trying to gather information to spread through gossip” (Ogunmefun et al., 2011).

The elderly caregivers are often condemned and stigmatized by virtue of their association with a family member who is HIV positive. Recent research in a rural area in the Mpumalanga Province of South Africa revealed that the stigma of AIDS “leads families to banish children who are infected with AIDS; husbands chase away wives who have become sick with AIDS; everyday life is structured by strenuous regimes of public secrecy and disavowal of AIDS; priests are frightened to mention the subject of AIDS at funerals; family members and partners of people living with HIV/AIDS have been stigmatized by association” (Ogunmefun et al., 2011). Older persons, who lost an adult child to HIV/AIDS, experienced gossip; name calling and rejection at the hands of community members; loss of livelihood; and being held responsible for the “bad” behavior of infected children. Stigma as well as witch hunt are manifestations of how deeply some of these social outcomes of the disease relate to structural issues, more than to HIV/AIDS alone. Many of the prevalent negative attitudes are fueled by cultural or local beliefs about the virus and its causes.

**Accusations of Witchcraft**

Accusation of witchcraft are another symptom of cultural explanations to the disease. The abuse resulting from the accusation of witchcraft is a unique case of abuse as it often befalls older women who, because of their physical appearance (appearance of extensive wrinkles) physical limitations (walking slowly, dragging of legs) and sometimes mental incoherence (talking to oneself, talking in a confused manner), are labelled as witches. Once suspected, these women are
strongly stigmatized and ostracized by the community. They suffer psychological abuse in being socially isolated and verbally assaulted. Sometimes they suffer physical abuse and in several cases are set alight and killed for being witches (Keikelame & Ferreira, 2000; Department of Social Development, 2001b).

HIV/AIDS are often rationalized through the lens of witchcraft in African culture: “the practice persists in poor settings in part because witchcraft can be used in communities without routine access to modern medicine and science to explain seemingly inexplicable instances of death and misfortune” (Mgbako, 2011). For example, in a similar society (Malawi), the community – like so many others across Malawi – believed that HIV/Aids deaths were caused by a curse from God. They believed that curse was cast by witches. And a witch was anyone who lived to be "very, very old" or in local parlance, anyone over the age of 60 (Southam, 2012).

Witchcraft is strongly associated with the abuse of older persons, especially women. At least 75 percent of the women who appeared as victims in witchcraft cases in the Thohoyandou Magistrate's Court (Venda) were elderly. They are often frail and less powerful as their assailants, they are therefore seldom able to resist attack. They are sometimes perceived to do no work for their share of the wealth. For example, they would be not yet working when the youths leave early in the morning for school or other activities and they would have completed their daily tasks when the youths return late in the day. There is a belief in Venda that women have many secrets and that by the time they are old they know about many things. Hence the Venda saying that: "All women are the same and all women are witches” (Minaar, Wentzel & Payze, 1998).

In this context, medical issues are interpreted in a cultural sensitive manner. For example, 80 percent of sick people seek attention of a traditional healer in South Africa before seeking a doctor (HHI’s Holiday Lectures Video Extras, 2008). The police men who execute ‘witches’ to
their communities are held as selfless heroes committed to 'freeing' people from 'supernatural evils'. Police are fighting a losing battle as they address only the symptoms of a deep-rooted problem. “The problem is that police can only act against those who physically attack the victims - not against those who indoctrinate the youths to believe in witchcraft. The master-minds behind the killings are often left alone” (Department of Social Development (2001b).

Which hunts, the heavy stigma and the reliance on ‘traditional healers’ and medicine actively complicate elderly’s difficulties and suffering in dealing with the disease. This section show how the HIV/AIDS epidemic effects on the elderly are exacerbated by the structural factor of culture. These two phenomena embody the additional hardships that the elderly are subjected to as a result of the coincidence of HIV/AIDS and traditional beliefs, specifically to the South African society.

**CONCLUSION**

**Complex Causation: from the Abuse to the Positive Experience**

Many scholars have attributed the hardships of the elderly mainly to the impact of HIV/AIDS. Instead, this discussion has highlighted how HIV/AIDS has worsened a situation which was already complicated by a series of pre-existing structural issues. HIV/AIDS’s extreme incidence in the country is one of the key components causing the extremely problematic situation of the elderly in South Africa, but it is not the only one nor the most important. Government policies made to halt the epidemic may have been successful if applied in a different context without structural racism, inherent socio-economic differences between Blacks and Whites, extreme poverty and traditional values like witchcraft. Furthermore, this complex causation highlights
two aspects: the neglect and lack of services geared specifically towards the elderly; and at the same time elderly's resourcefulness and contribution to society.

The first relevant conclusion is that even though struggling to share their resources with their loved ones and their community, the South African elderly are neglected and do not receive proper education, medical services and pensions. The focus of this paper has been primarily their important role in society, but the goal of this analysis should not be erroneously identified only with the benefits provided to other age groups. As explained in the first part of this paper, seniors are depositary of human rights and as a vulnerable group should be entitled to specific benefits to allow them to live a long and comfortable life.

Secondly, this paper has sought to highlight how the elderly, most of all women, who as a collective would usually be considered fragile and weak, are themselves taking care of other vulnerable household members – ill adult children, and fostered and orphaned grandchildren. It is therefore important to recognize the roles that they play and their relevance in sustaining and managing the multi-generational households in which they live. Older women in African traditional societies do not take care only of their orphaned kin, even though it is clear that the responsibilities associated with caring for those sick with HIV/AIDS and the children left behind are great (Hutton, 2008). The South African case is therefore an important example from which to learn.

The traditional idea of frail and weak elderly cared for by the youth has been proved not to hold for many older South African people. The elderly now play a wide range of roles, including managers of family budget; distributors of social pensions to younger generations; providers of informal and traditional health-care; carers for sufferers of terminal disease and their dependents (as the prevalence of AIDS escalates, this role is set to become increasingly
prominent); child-carers for employed or ill family members with children; and custodians of traditional values (May, 2003). It is therefore important to observe that the older population as a whole is neither helpless nor dependent. Most older people are capable of coping and adapting, despite increasing poor health and frailty as they age. In order to contribute immeasurably to their families and communities in various roles, older people commonly sacrifice their well being to help their children and grandchildren. Indeed, many of those that fell into poverty once their ill progeny had come back home still claimed that it was their duty and their pleasure to care for the terminally ill and their grand-children.

Finally, seniors contribute to their communities with their decades of accumulated experience, knowledge and understanding. Traditional African culture values the elderly for this reason. On one hand, traditional beliefs can be a threat to aging because of possible accusations of witchcraft. On the other, elderly’s wisdom and experience give them a wide range of influence in which their opinion is esteemed. This is why understanding traditional culture and starting from educating traditional healers and elderly who have an extended network of relationships could be useful to spread awareness on HIV and redirect those with symptoms to the appropriate care.

Elderly’s traditional role makes them also a useful resource and potential partner in developing emergency preparedness and response programs. Since 1956, the NGO South AfricaCA has championed the cause of older persons and, through its People Empowerment Programmes, it has created over 400 organizations that are unique in their nature of service delivery. This program actively engages older persons in serving their peers and their communities, showing once again how elderly, if seen as a resource and not a frail victimized population, can be mobilized to actively bring change into society (Reddy, 2002).
AfricaCA has adopted a multifaceted programme for tackling the issue of elder abuse in South Africa, ranging from prevention and early detection to active intervention. It has created shelters for those older persons who have been abused, or who are destitute. It has also recognized the lack of experience of health professionals and allied professionals to deal with elder abuse. In response to this need, South AfricaCA (with the assistance of the University of South Africa) has enabled health professionals to attend an accredited training programme on Victim Empowerment that trains professionals in the understanding of elder abuse and how to respond in such cases. This is one example of how civil society and NGOs can play a very important role in aiding the state government through spreading awareness and in organizing elderly to help others and themselves.

Objections and Future Research

Some scholars have casted doubts on the role of grandparents into bringing significant change. They argued that too much causal power cannot be attributed to HIV/AIDS in changing the South African family structure and society. For example, particularly relevant for this discussion, is how Chazan (2008) criticizes the attitude of some advocacy efforts to depict elderly’s plight as if, “if it were not for AIDS, grandmothers in high-prevalence African countries would be enjoying a restful retirement.” Although this is not the case, the role of the elderly cannot be discounted in coincidence with the high rates of death caused by HIV/AIDS. The fact that elderly in traditional South African societies have always felt a sense of responsibility in caring for those in need does not change the fact that the epidemic has created a much larger number of dependents and has weakened an already frail health and pension system, impacting the elderly’s overall capacity of caring for the ill and young. Therefore, even though HIV/AIDS has not solely
changed drastically the situation and has not created this phenomenon anew, it has certainly worsened the quality of life of seniors as demonstrated by the above discussion.

Secondly, Chazan points out that the elderly cannot be seen as old and frail as in North-American and European societies because “most South African women become grandmothers when aged in their thirties and forties.” However, our discussion has highlighted how because of the hardship and poor health conditions in which they live, most household-heading women tend to show syndromes that affect elderly in developed societies by the time they are 30 or 40. So, it is not warranted to assume that because of their age South African grandmothers do not suffer the physical consequences of their burdens.

A myriad of issues arise from the effects of the HIV/AIDS epidemics which impact the sustainability of family units and family networks in the subregion. Even though the objections raised by Chazan do not discount the validity of the cited literature, some recommendations can be made for future research in order to give a more comprehensive picture of the issues in South Africa. Particularly, family related issues tend to be eclipsed in the literature, which has historically focused on specific generational effects of the epidemics. This discussion for example has focused on older persons as caregivers. But it also attempts to contextualize this issue into a more general picture: effects of the disease and associated illness and deaths on families, family structures, intergenerational relations and family capital as a whole. More research can be done on the topic to show how elderly give a vital contribution to societies in need (Ferreira, 2004).

Secondly, as the focus of the paper has been the elderly, other age groups have not been dealt with. It is important to note that the changing roles of grandparents, or surrogate parenthood, as a result of the epidemics has resulted in changed relationships between the oldest
and youngest generations. Children who become heads of households and must care for other children also experience role changes. Research should also investigate the issues of these young generations who, similarly to the elderly, lose their care-givers and are put in the position of care-givers themselves.

This being said, seen the dire situation that elderly face, it is important to expand the research on their issues in order to raise the international community’s interest, and so that governments and policy makers will be prompted to move towards the incorporation of the elderly in their processes. The first issue that should be addressed by future research is the still widespread racial inequality that affects the elderly though disparity in access to nursing homes and entitlements. Extreme poverty and apartheid left marks that will never be healed in the lifetime of the ones who witnessed it. But their socio-economic effect can be seriously tackled as the root cause before proceeding to enact doomed social policies to try to bring in a change. Scholarly expertise on policy and the analysis of their effects tailored to the context of South Africa would provide useful guidelines for policy-makers.

Secondly, more studies should be carried out arguing that the elderly, reconsidered for their potential in bringing social change, should be educated with literacy programs in order to claim their rights. As demonstrated by the above discussion, elderly awareness of their rights to entitlements brings redistribution of resources to all the dependent and younger generations. Advocacy efforts on elderly training to recognize HIV/AIDS symptoms would be welcome, as these would train the older persons to redirect the sick to the appropriate care and avoid traditional healers. This could have a great social and medical impact in order to contain the HIV/AIDS epidemic, seen the importance of the elderly as many rely on their opinion according to traditional values.
Thirdly, governments and NGOs should put a serious effort into providing specialized geriatric medical services and support to the elderly caregivers, in order to allow them to be healthy as long as possible and keep playing an important social role.

Finally, the elderly should be consulted and actively included in policy drafting as they are clearly aware of the challenges the society faces. The elderly can provide context-sensitive insights and suggest ways in which solutions can be introduced according to cultural and social values.

Similarly to these recommendations, the UNHCR in 1999 concluded: “While the elderly clearly have special problems there is little to be gained from establishing yet another separate refugee category with [a] distinct set of guidelines and interventions such as those devised for refugee women and children. What is clearly required, however, is a more targeted inclusion of the elderly in all aspects of programme, of planning and implementation, with the aim of helping young elderly to be more self-supporting and promoting better community care initiatives for the very old” (Hutton, 2008).
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